

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION



**BROOMFIELD PEDIATRICS**  
**3301 W. 144th Ave., Ste. 200**  
**Broomfield, CO 80023**  
**303-438-5522**  
**303-438-5686 Fax**

## PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Broomfield Pediatrics to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Broomfield Pediatrics to use or disclose information on myself to \_\_\_\_\_ .  
The following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc...)

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When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Broomfield Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Broomfield Pediatrics at 3301 W 144th Ave #200, Broomfield, CO 80023.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Patient or Legal Guardian**

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